

Post-market review of Opiate Dependence Treatment Program (ODTP) medicines: stakeholder forum summary

The stakeholder forum was held as a webinar at 2.30 pm AEDT on 24 February 2022. It consisted of presentations from the department, 11 multiple choice questions that participants answered in a live poll, a series of discussion questions, and a question and answer session. Participants were also invited to send any further comments to the department after the webinar.

Of 97 participants attending the forum, 10 were associated with the department, and 87 were external participants.

This document provides a broad summary of the views expressed by stakeholders at the forum (or through provision of further comments after the webinar). No attempt has been made to reach consensus.

Key points from the forum

Participants identified a range of issues with the ODTP:

- Overall, the program is outdated and out of step with international models.
- Consumer access and consumer out-of-pocket costs when accessing their medicines from dosing sites are critical issues. Participants felt very strongly that ODTP medicines are a publicly funded treatment for a chronic condition and should be provided at the same or similar costs to the consumer as other Pharmaceutical Benefits Scheme (PBS) medicines. ODTP consumers should have equitable access to the PBS Safety Net, as they would for any other chronic condition.
- Consumer choice is important to strengthen and maintain, including choice of medicine, formulation and provider.
- The requirement for supervised dosing should be reviewed, particularly for buprenorphine products. Methadone could be considered separately as it has a different toxicity profile.
- The lack of an adequate funding model for prescribers (particularly GPs) was a significant barrier to prescriber participation in the program.
- The cost and complexity of the program for pharmacists is a significant barrier. Participation in the ODTP is not financially viable for many pharmacists, and the Australian Government covering the cost of the medicine alone through the PBS does not improve consumer access or quality use of medicines.

Participants identified the following opportunities for consideration in the review:

- A revised ODTP could be guided by overseas experiences, and by programs for other medicines within Australia (such as opioids prescribed for different indications), or could be similar to how other medicines are listed on the PBS either on the PBS General Schedule (s85) or under s100 of the *National Health Act 1953*.
- Many lessons can be learned from changes to treatment models during COVID-19 restrictions, which demonstrated that changes to the way medicines are dispensed, delivered and managed under the ODTP are possible.

- Changes to the program will need to consider the range of public and private organisations that provide services under the ODTP, and ensure that access is maintained across the spectrum of dosing points.

Purpose and context

The aim of the stakeholder forum was to ensure that the report of the Pharmaceutical Benefits Scheme (PBS) post-market review of medicines for the Opiate Dependence Treatment Program (ODTP) includes the views of a wide range of stakeholders, and that these views inform the discussions about future options for the Pharmaceutical Benefits Advisory Committee (PBAC) to consider. The PBAC is an independent expert advisory body with a primary role to recommend to the Minister for Health new medicines for listing on the PBS. This summary of stakeholder input received at the forum will be included in the review's report to the PBAC. The final report to the PBAC and the Minister for Health is expected to propose improved service delivery arrangements for access to opioid dependence treatment medicines through the PBS.

All stakeholders who have an interest in the ODTP were invited to participate in the forum, including industry, peak bodies, consumers (and consumer advocacy organisations), prescribers, pharmacists, and state and territory government representatives.

Department presentations

The department explained the post-market review framework, including when and how stakeholders will be consulted. Forum participants were informed that separate focus groups will be held with consumers of ODTP medicines to ensure their experience and views are also fully considered and inform future options for the PBAC. The final report to the PBAC and the Minister for Health is expected to propose improved service delivery arrangements for access to ODTP medicines through the PBS.

The department provided an overview of the ODTP. Three medicines are provided under the program (the review is limited to the medicines currently listed on the PBS and available under the ODTP):

- buprenorphine (sublingual tablets and modified release injections)
- buprenorphine with naloxone (sublingual films)
- methadone (oral liquid).

Currently, the Australian Government pays the full cost of ODTP medicines, and state and territory governments are responsible for program administration (including approving the participation of prescribers, dispensing sites, and enrolling clients, as well as regulations for prescribing, supply and supervised dosing of these medicines). This makes the ODTP different from other PBS programs. ODTP clients are not charged a standard PBS co-payment, and no Commonwealth subsidy is provided for dispensing and dose management activities. The majority of ODTP clients access their medicines from community pharmacies, but other dosing sites include correctional facilities, clinics and other health services.

The department described the PBS arrangements under the *National Health Act 1953*. General schedule medicines (s85) are often supplied to consumers on a monthly basis, attract a set PBS co-payment (which contributes to a person's safety net threshold) and access is largely limited to dispensing in the community pharmacy setting only. Section 100 (s100) of the *National Health Act*

1953 allows for special arrangements to be made if a general schedule listing is inadequate for certain medicines – for example, this could be to support access to medicines from non-pharmacy access points. Duplication of medicines across multiple schedules is rare. Where this occurs in the PBS, there are usually differences relating to indications for use, formulation, strength of the medicine and maximum quantity that can be prescribed. Running two different parallel programs through s85 and s100 has the potential to create a more complex and duplicative program.

Importantly, the ODTP is not like other PBS programs, as opioid dependence treatment more broadly is administered and regulated by states and territories.

The department noted the review is planned to be finalised in September 2022.

The slides for these presentations are available on the [Review webpage](#).

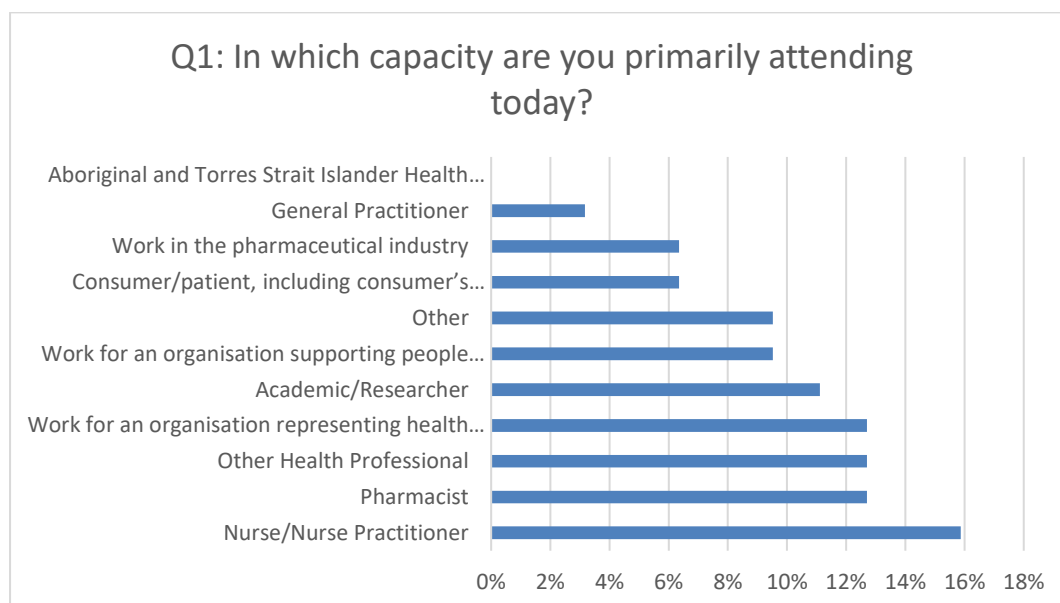
Responses to poll questions

Respondents answered the following questions in a live poll during the forum. It was noted that some participants were not able to use the live poll function due to administrative restrictions on their IT networks.

1. In which capacity are you primarily attending today? (pick one)

- Consumer/patient, including consumer's support network
- General Practitioner
- Nurse/Nurse Practitioner
- Aboriginal and Torres Strait Islander Health worker
- Pharmacist
- Other Health Professional
- Academic/Researcher
- Work for an organisation supporting people with opioid dependence
- Work for an organisation representing health professionals
- Work in the pharmaceutical industry
- Other

The highest proportion of participants were nurses or nurse practitioners (16%), followed by pharmacists (13%), other health professionals (13%), and organisations representing health professionals (13%). No participants identified as representing an Aboriginal and Torres Strait Islander health service.

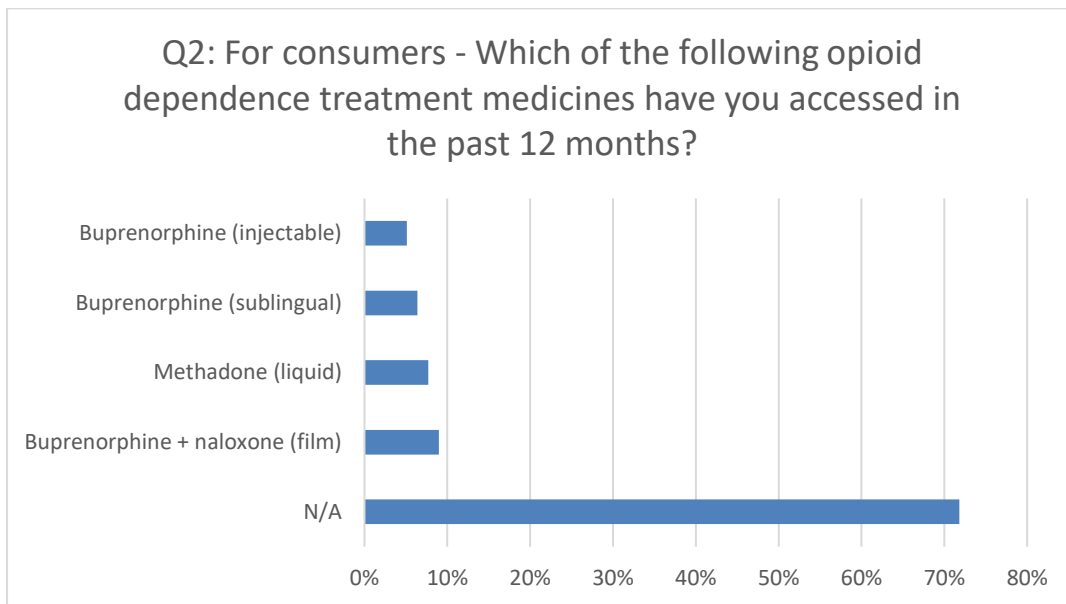


Total number of responses = 63

2. For consumers - Which of the following opioid dependence treatment medicines have you accessed in the past 12 months? (pick all that apply)

- Buprenorphine (sublingual)
- Buprenorphine + naloxone (film)
- Buprenorphine (injectable)
- Methadone (liquid)
- N/A

More than 71.8% of poll responses were 'not applicable'. Buprenorphine + naloxone film received the highest number of remaining responses (9.0%), followed by methadone liquid (7.7%), buprenorphine sublingual (6.4%) and buprenorphine injectable (5.1%).

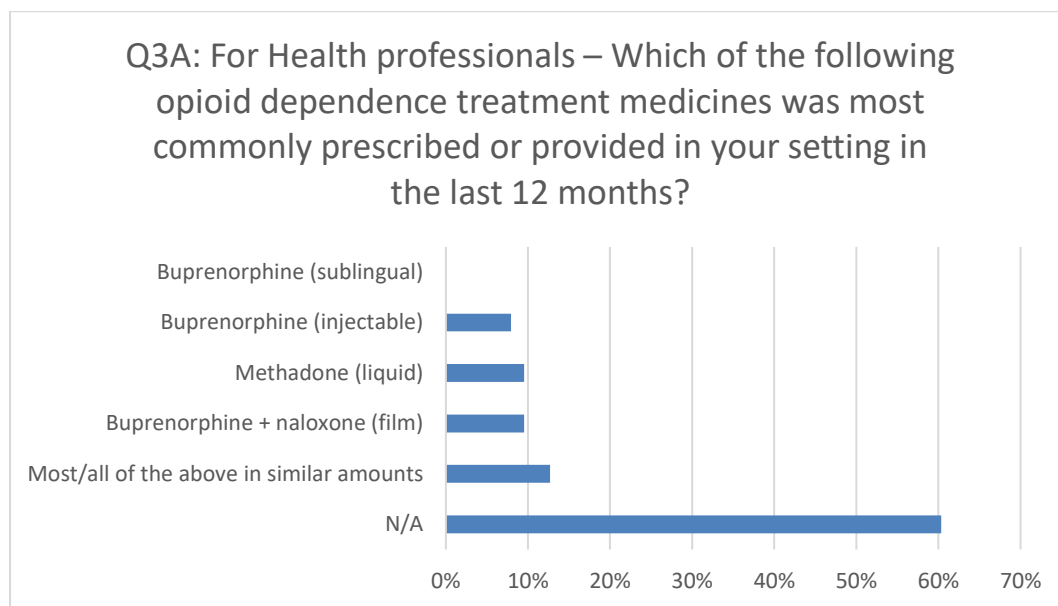


Total number of responses = 78

3. A. For Health professionals – Which of the following opioid dependence treatment medicines was most commonly prescribed or provided in your setting in the last 12 months? (pick one)

- Buprenorphine (sublingual)
- Buprenorphine + naloxone (film)
- Buprenorphine (injectable)
- Methadone (liquid)
- Most/all of the above in similar amounts
- N/A

60.3% of poll responses were 'not applicable'. 12.7% of responses indicated most/all of the above in similar amounts, 9.5% indicated buprenorphine + naloxone film, 9.5% indicated methadone liquid, and 8.0% indicated buprenorphine injectable. No responses indicated buprenorphine sublingual.

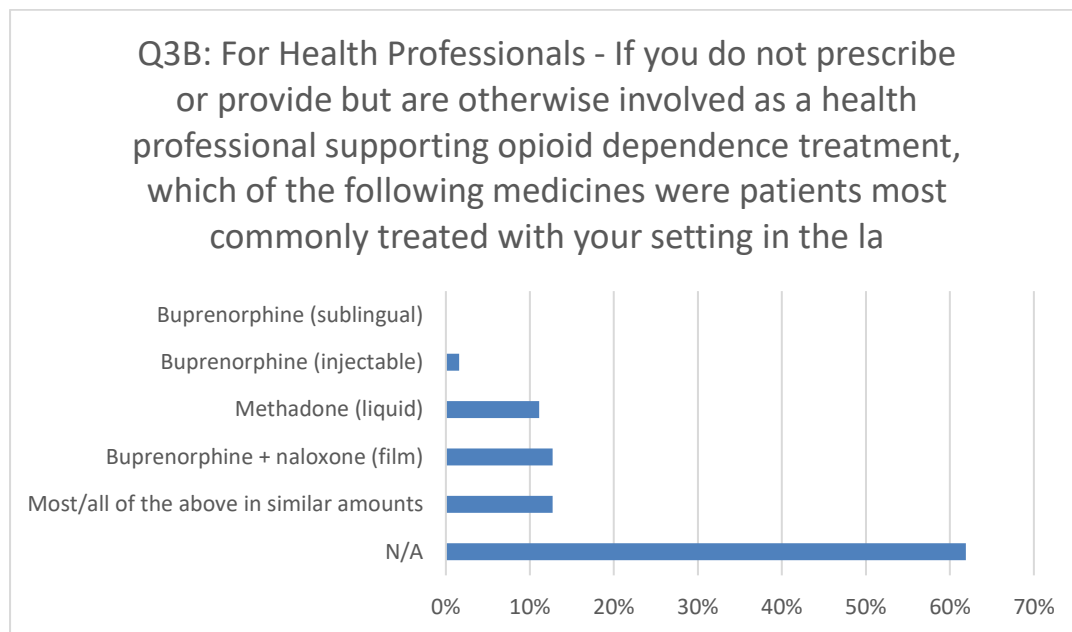


Total number of responses = 63

3. B. For Health Professionals - If you do not prescribe or provide but are otherwise involved as a health professional supporting opioid dependence treatment, which of the following medicines were patients most commonly treated with your setting in the last 12 months? (pick one)

- Buprenorphine (sublingual)
- Buprenorphine + naloxone (film)
- Buprenorphine (injectable)
- Methadone (liquid)
- Most/all of the above in similar amounts
- N/A

More than 61.9% of poll responses were 'not applicable'. 12.7% of responses indicated most/all of the above in similar amounts. 12.7% of responses indicated buprenorphine + naloxone film, followed by methadone liquid (11.1%) and buprenorphine injectable (1.6%). No responses indicated buprenorphine sublingual.

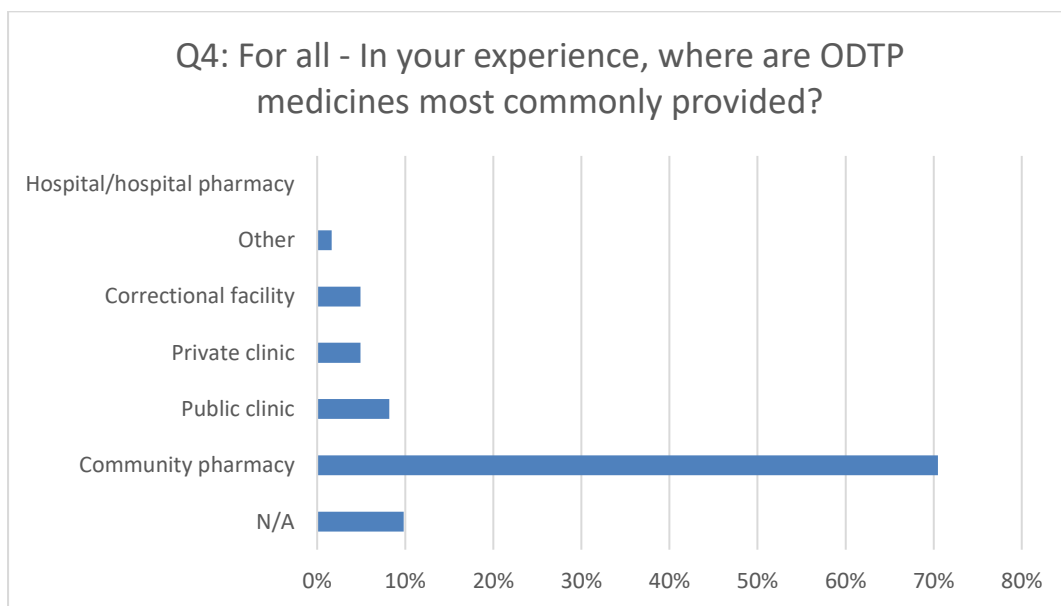


Total number of responses = 63

4. For all - In your experience, where are ODTP medicines most commonly provided? (pick one)

- Community pharmacy
- Public clinic
- Private clinic
- Hospital/hospital pharmacy
- Correctional facility
- Other
- N/A

Community pharmacy received the highest number of responses by far (70.5%). Remaining options received less than 10% of responses each, and no participants selected 'hospital/hospital pharmacy'.

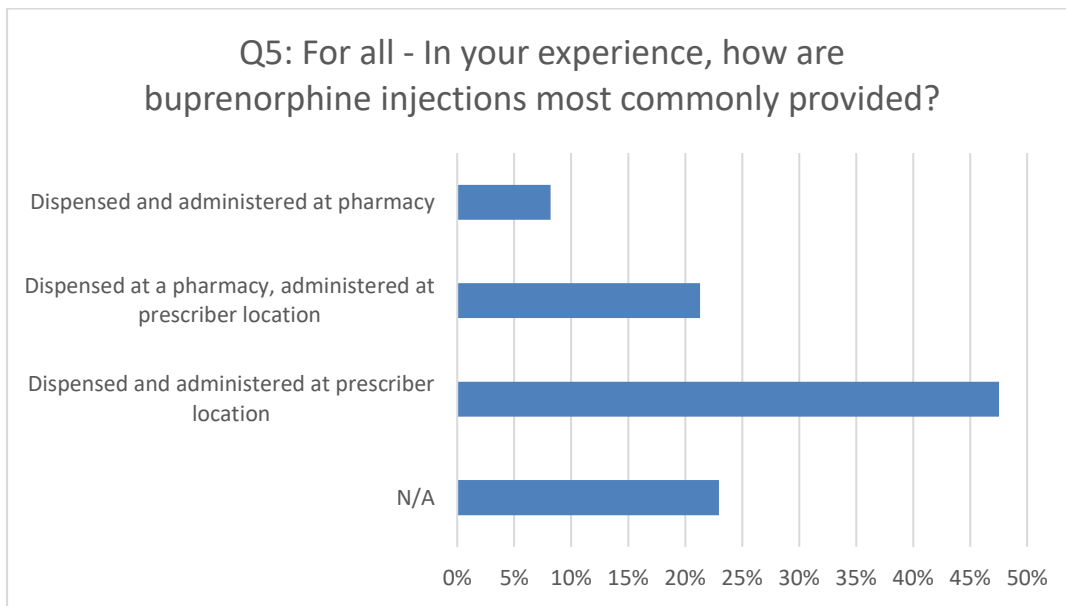


Total number of responses = 61

5. For all - In your experience, how are buprenorphine injections most commonly provided? (pick one)

- Dispensed and administered at prescriber location
- Dispensed at a pharmacy, administered at prescriber location
- Dispensed and administered at pharmacy
- N/A

Almost half (47.5%) of responses were 'dispensed and administered at prescriber location'. 21.3% of responses were 'dispensed at a pharmacy, administered at prescriber location', and 8.2% were 'dispensed and administered at pharmacy'. 23.0% of responses indicated 'not applicable'.

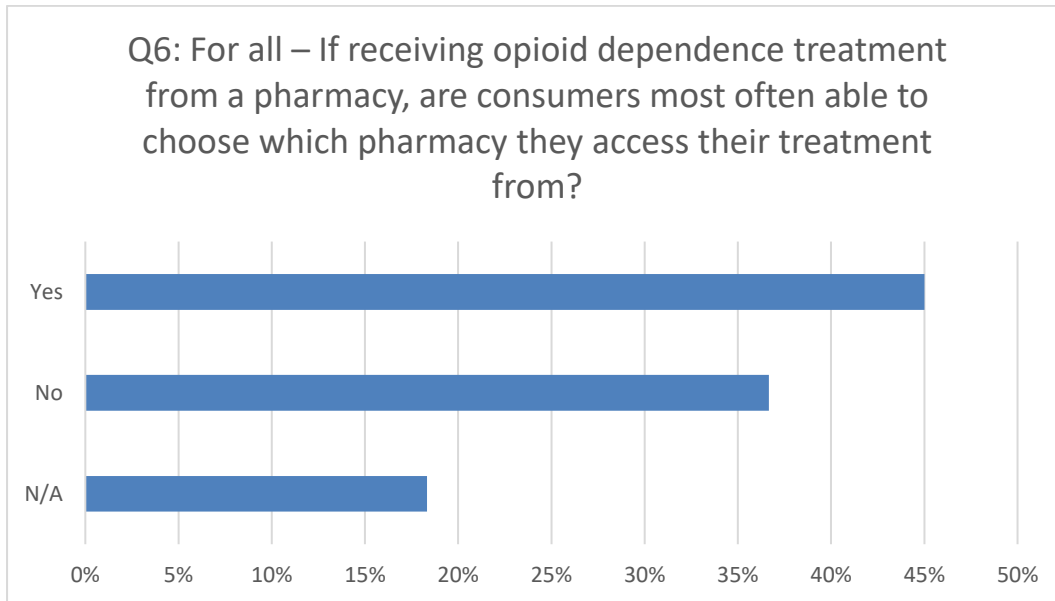


Total number of responses = 61

6. For all – If receiving opioid dependence treatment from a pharmacy, are consumers most often able to choose which pharmacy they access their treatment from? (pick one)

- Yes
- No
- N/A

45.0% of responses indicated that consumers could choose the pharmacy, and 36.7% indicated there was no consumer choice. 18.3% indicated 'not applicable'.

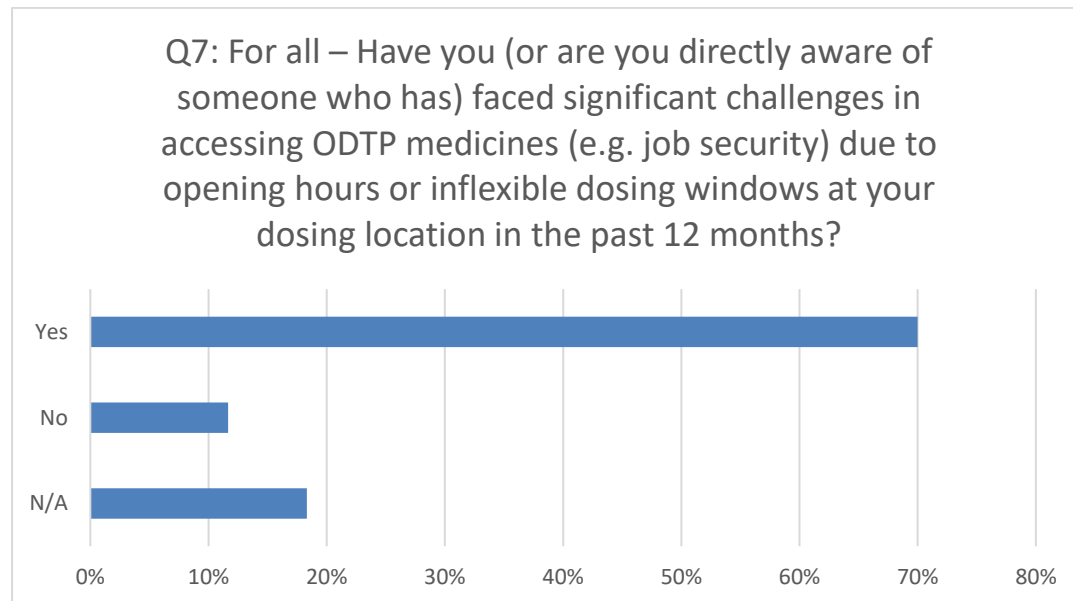


Total number of responses = 60

7. For all – Have you (or are you directly aware of someone who has) faced significant challenges in accessing ODTP medicines (e.g. job security) due to opening hours or inflexible dosing windows at your dosing location in the past 12 months? (pick one)

- Yes
- No
- N/A

70.0% of responses indicated 'yes', 11.7% indicated 'no' and 18.3% indicated 'not applicable'.

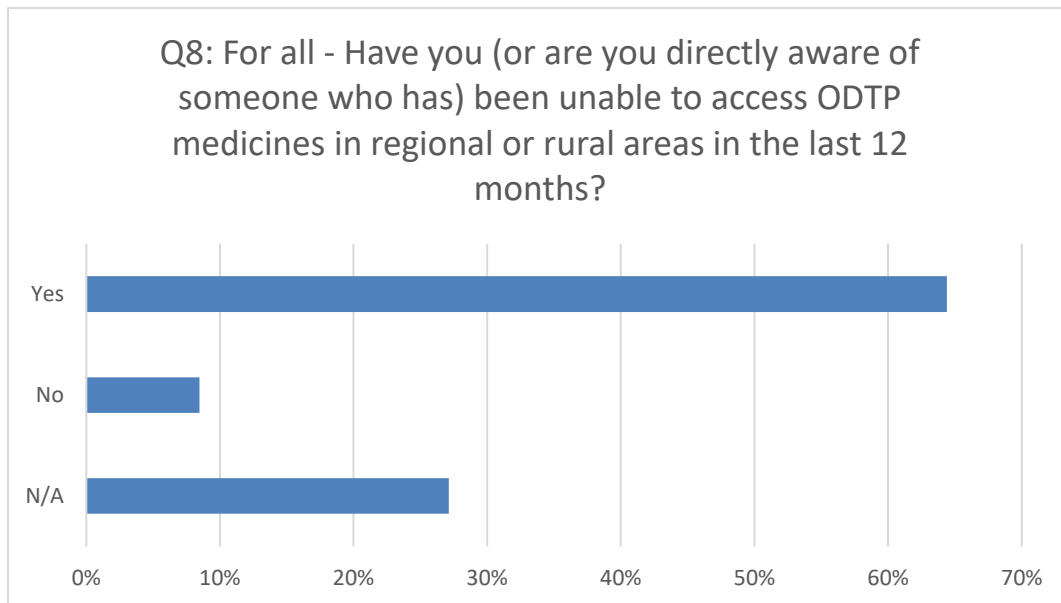


Total number of responses = 60

8. For all - Have you (or are you directly aware of someone who has) been unable to access ODTP medicines in regional or rural areas in the last 12 months? (pick one)

- Yes
- No
- N/A

64.4% of responses indicated 'yes', 8.5% indicated 'no' and 27.1% indicated 'not applicable'.

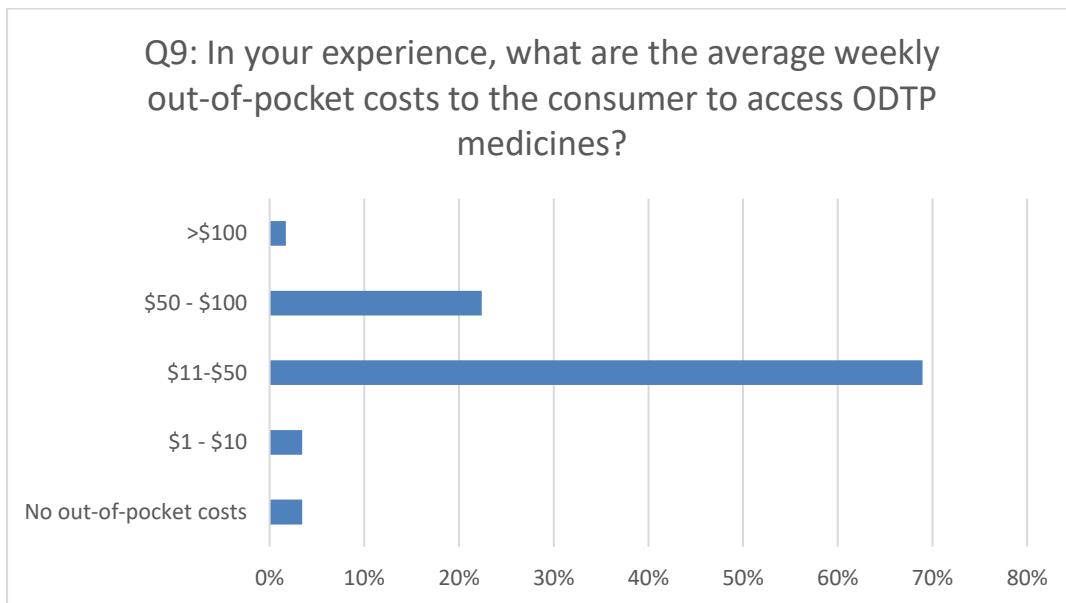


Total number of responses = 59

9. In your experience, what are the average weekly out-of-pocket costs to the consumer to access ODTP medicines? (pick one)

- No out-of-pocket costs
- \$1 - \$10
- \$11 - \$50
- \$50 - \$100
- >\$100

The most common price range was \$11–50 (69.0% of responses), followed by \$50–100 (22.4% of responses). Only 3.4% of responses indicated no out-of-pocket cost.



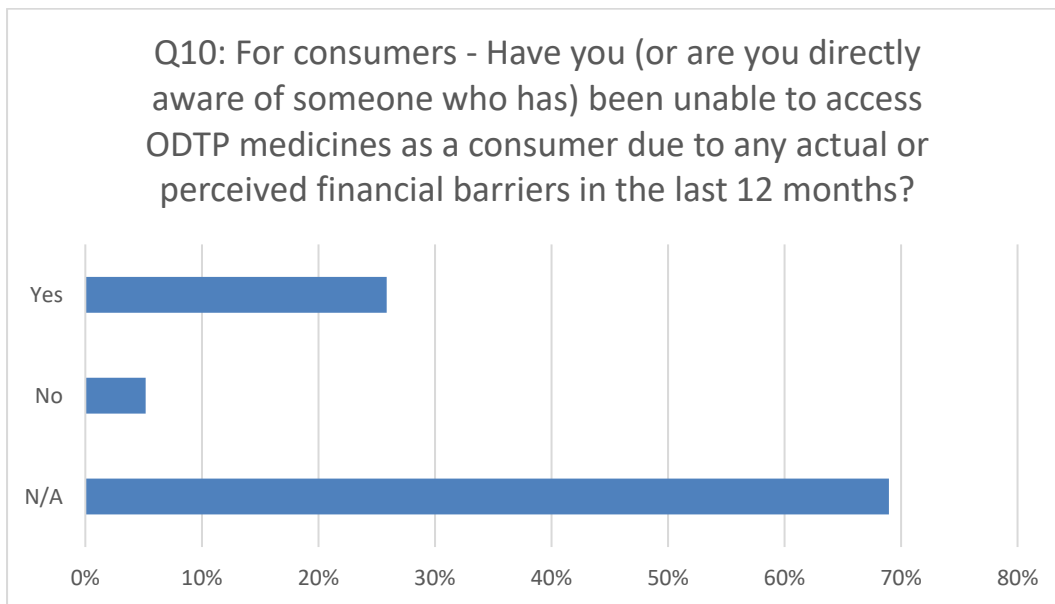
Total number of responses = 58

10. For consumers - Have you (or are you directly aware of someone who has) been unable to access ODTP medicines as a consumer due to any actual or perceived financial barriers in the last 12 months? (pick one)

- Yes
- No
- N/A

If yes, please provide a brief description in the chat.

Most responses (69.0%) indicated 'not applicable'. 25.8 indicated 'yes' and 5.2% indicated 'no'.



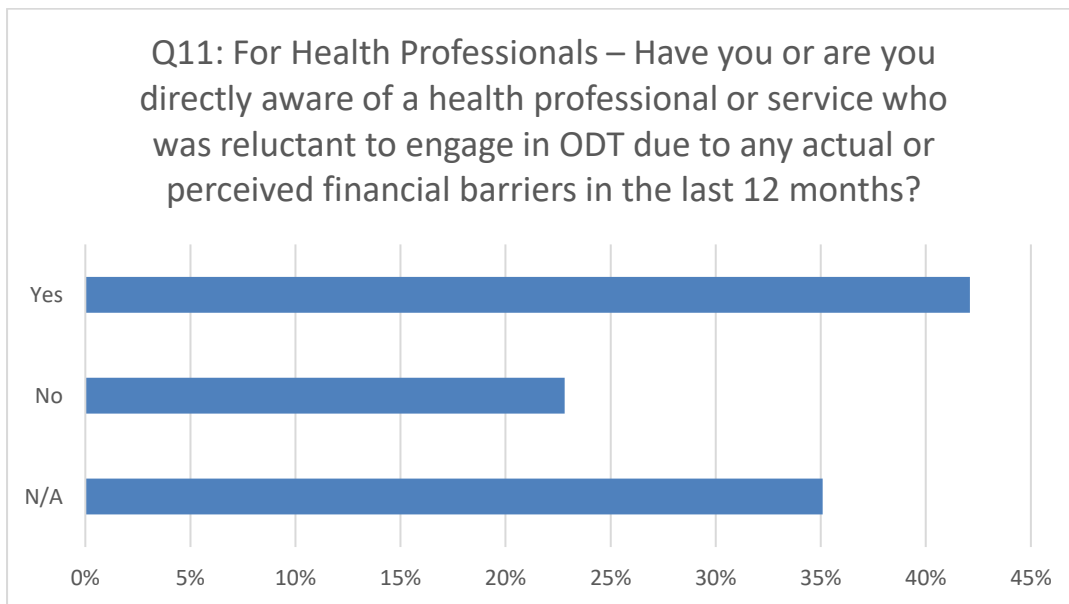
Total number of responses = 58

11. For Health Professionals – Have you or are you directly aware of a health professional or service who was reluctant to engage in ODT due to any actual or perceived financial barriers in the last 12 months? (pick one)

- Yes
- No
- N/A

If yes, please provide a brief description in the chat.

42.1% of responses indicated 'yes', 22.8% indicated 'no' and 35.1% indicated 'not applicable'.



Total number of responses = 57

Discussion session

Participants were prompted with the following questions for discussion:

- What aspects of the current system work well in your setting? In that context, what elements of the program do you think should continue in any reformed version of the program?
- If you haven't introduced or are in the process of introducing opioid dependence treatment (ODT) into your service, what are the barriers?
- What are the barriers for you, or for others you know, to scale up ODT?
- What needs to change to overcome the barriers to access?
- Would barriers to access be addressed if medicines for ODT were PBS listed similar to other PBS medicines? Could there be any unintended consequences if ODT medicines were PBS listed similar to other PBS medicines?
- In a pharmacy setting, would remuneration for the supply of ODT medicines enable the program to be scaled up so that more people can receive treatment? What else would facilitate scaling up?
- Please describe how the supply chain for ODTP medicines works in your setting i.e. for sponsors /wholesalers/community pharmacy/non-pharmacy dosing sites?
- How has the introduction of long-acting injectable buprenorphine (LAIB) affected ODT? What is working well in regard to this product in your setting and what can be improved?
- COVID-19 has highlighted challenges with the provision of ODT services but might also be said to have created some opportunities to innovate how ODT is delivered. What are the lessons learnt during the pandemic and how can they inform future improvements to the ODTP?
- Is there any other constructive feedback about your experience with ODT medicines that you can provide?

Many of the issues discussed were overlapping, and discussion has been categorised under the following themes.

Overall comments on the ODTP

Participants considered that the Australian Government should continue to pay for the cost of ODTP medicines. Participants also mentioned that the range of treatment options and applicability in different settings is important to retain (e.g. the availability of LAIB in correctional settings), as well as distribution of medicines to, and access through, community pharmacies.

However, participants considered that there are many legacy issues that mean the ODTP is outdated and out of step with some aspects of international models. The current ODTP model was appropriate when all services were delivered through public hospitals and drug and alcohol services, but today the ODTP is accessed almost entirely through GPs and community pharmacies. Medicines available under the program have changed over time, with new formulations that require different models of care (e.g. for LAIB). The types of clients accessing the ODTP has also changed over time. One participant noted that the majority of clients in their service were being treated for medical dependence on opioids, and the number of people who were seeking opioid dependence treatment due to use of illicit drugs had substantially decreased in this service.

Consumer access

Consumer access and the cost of accessing medicines for the treatment of opioid dependence were identified as key issues to consider as part of this review. Participants felt very strongly that ODTP medicines are a publicly funded treatment for a chronic condition, and ODTP consumers should therefore have equitable access to the PBS safety net arrangements, as they would for other PBS-listed medicines.

Cost to consumers can be significant, is unregulated and varies widely depending on the setting in which medicines are accessed. It was noted by some participants that many consumers pay \$40–50 per week for their treatment, and more through community pharmacies. Many consumers have limited incomes and need to make sacrifices to be able to pay the fees. It was noted that some consumers feel ‘trapped’ in public services for purely financial reasons, not because it is the best care for them. The consequences for not being able to pay the fees are exiting the program or conflict with their pharmacist. Participants considered these costs to be promoting inequities compared with other PBS-listed medicines. The department confirmed that options in relation to addressing consumer costs are expected to be an outcome of this review.

Participants noted that sometimes consumers exited the program because they were unable to attend a pharmacy every day. Some participants considered that the need for consumers to negotiate the current restrictive system that does not consider their individual needs actually increases the risk of harm and overdose, as opioid dependence treatment is a protective factor against overdose.

Access for rural and regional consumers can also be difficult, with fewer participating prescribers and pharmacies, and long travel times for consumers. This could be addressed with more flexible models of care, including unsupervised dosing. Participants also noted the issues relating to Aboriginal and Torres Strait Islander people, as described in several submissions to the review.

Issues of stigma are of significant concern for ODTP clients. Participants felt that stigma underlies the design and delivery of treatment for opioid dependence. Many clients need to go to a private area of the pharmacy to pick up their medicines, which perpetuates these issues. Participants considered that this does not align with the way that other chronic health conditions are managed.

Participants considered that models of care should generally be more flexible to fit in with consumers’ lives. This includes more seamless transitions for consumers to move between services – whether this is moving to another geographical area within their state or territory, moving to another jurisdiction, moving from a custodial setting to the community, or moving between public and private services – either temporarily (e.g. travelling for a holiday) or permanently.

Participants considered that any changes to the ODTP as a result of this review should increase consumer access, not reduce it. This would include not implementing patient service caps in any pharmacy program remuneration model.

Consumer choice

Participants considered that the variety of formulations of medicines for the treatment of opioid dependence available to clients is beneficial to consumer choice. Different medicines and means of delivery provide an opportunity to use processes in a revised ODTP that were not available in the past.

LAIB is often used for people in correctional settings, fly-in-fly-out workers or people who need to travel long distances to access their treatment. Participants appreciated LAIB as an option, but considered that it may not be the most appropriate treatment option or the preferred opioid dependence treatment medicine for everyone.

Participants noted that many consumers receive LAIB in correctional settings, but they are often unable to access a pharmacist to provide them with LAIB when they are back in the community. This may be for various reasons, including that their local pharmacy has reached their patient cap, or price differences between formulations. Participants considered that this compounded the existing issues for these often marginalised and disadvantaged members of the community.

It was noted that some consumers make treatment decisions based on whether they can receive takeaway doses, not whether that medicine or formulation is the best treatment for them. It is important that the treatment is determined by consumer choice and matching the best treatment for the person, rather than other factors such as convenience, availability of formulations or cost.

COVID-19 experience

Participants considered that many lessons could be learned from changes to service models during COVID-19 restrictions, which demonstrated that changes to the way medicines are dispensed, delivered and managed under the ODTP (such as providing increased takeaway doses for consumers) are possible.

Some participants noted that changes to the way the ODTP was delivered during COVID-19 restrictions resulted in no adverse outcomes. One pharmacist participant described a home delivery model that the pharmacy set up during COVID-19 restrictions. Around 300 home deliveries were made to people who otherwise would have either missed doses or breached quarantine to visit the pharmacy, with only one adverse incident reported.

Many participants felt that COVID-19 restrictions confirmed that consumers are capable of managing their health and wellbeing, including through unsupervised dosing. It was suggested that the fears that led to the current restrictive system were not realised. Other participants felt that more data analysis is required to be able to assess the effect of COVID-19 on the ODTP. One participant indicated that comparable overseas data/research on methadone in particular is scarce, and further consideration may be necessary to consider the benefits and risks.

Supervised dosing

There was considerable discussion about supervised vs unsupervised dosing, as this has a significant impact on clients' treatment. State and territory health departments have responsibility for guidelines and regulation of takeaway doses of pharmacotherapy. Participants considered that the requirement for supervised dosing should be reviewed, as there are different models of supervised and unsupervised dosing in other countries that Australia could learn from, as well as the experience in Australia during COVID-19 restrictions.

Participants considered that there were less reasons with regard to safety to prevent unsupervised dosing of buprenorphine products. However, different views were expressed regarding supervised dosing remaining an option for methadone, due to its different toxicity profile and risk of diversion.

It was suggested that signs of methadone poisoning had been seen in the community during COVID-19 restrictions, but it was difficult to tell if this was due to unsupervised dosing or other reasons. The more unsupervised dosing of methadone, the more episodes of poisoning are seen in

consumers. However, it was noted that the entire treatment of opioid dependence was constructed around this risk, even though this issue relates to a very small proportion of opioid dependence treatment clients. This may lead to suboptimal outcomes for many clients who are not taking methadone. In addition, the many clients who receive methadone should also have access to a flexible and effective program.

It was suggested that research and models of care from other countries could be explored in relation to methadone takeaway doses; for example, the United Kingdom's 'Pharmacist ODTP Prescriber' model. However, participants cautioned using data from the United States, as the health care system and social issues are significantly different to those in Australia. Some participants considered that enough Australian research was already available to inform this decision, but it requires consideration of the risks that society is willing to accept in relation to this issue. Some participants considered that policies should remain in place to protect the most vulnerable people in the community, such as those who do not have safe storage options, or those at risk of coercion with takeaway doses. However, other participants considered that risk profiling of consumers to determine their suitability for takeaway doses was another form of discrimination.

Participants suggested that methadone could be considered separately to other ODTP medicines as part of this review in relation to supervised dosing. Data could be sought from the coroner's court to learn more about the circumstances leading to methadone deaths.

Participants suggested that lessons could be learned from risk management of other medicines that have similar toxicity profiles to ODTP medicines. Although other medicines may not have the same risks of diversion, some useful comparisons could be drawn, such as chemotherapy, opioids prescribed for cancer-related pain or benzodiazepines. For example, for chemotherapy medicines, participants noted the processes in place to ensure safety and quality at every stage of preparation, and the associated fees that acknowledge the different handling and safety measures associated with these medicines.

Prescriber perspective

Participants considered that the lack of an adequate funding model for prescribers (particularly GPs) was a significant barrier to prescriber participation in the program.

Participants noted the small proportion of GPs who participate in the program, estimated at 15% of all GPs, and less than 5% of GPs in some jurisdictions. The attrition rate among GPs is high. In some locations (particularly regional and remote areas), if a single prescriber chooses to no longer participate, it puts the entire program at risk in that area. There are many reasons that GPs are unwilling or unable to participate, including lack of specific reimbursement items through Medicare for consultation time for clients in opioid dependence treatment (which is longer than 15 minutes) and administration time.

Depot buprenorphine is mainly dispensed and administered through GPs rather than community pharmacies. There is no clear funding model for this to ensure that costs are not transferred to consumers.

Participants suggested that the participation rate for prescribers could be vastly improved with a robust, fully funded model through the Medicare Benefits Schedule (MBS; although it was noted that a review of MBS items was out of scope of this review). Participants considered that listing ODTP medicines on the PBS alone does not recognise the exceptional nature of the care required by prescribers of opioid dependence treatment medicines (who are authorised to participate by state and territory health departments), nor would it address these issues with accompanying

arrangements for dose management for oral treatments or service requirements for administering depot buprenorphine. However, mainstream funding through the MBS would firmly establish opioid dependence treatment as a chronic health issue.

Funding for pharmacists

Participants identified a range of barriers to pharmacist participation in the ODTP:

- Lack of a holistic funding model and framework – covering the cost of the medicine alone does not improve consumer access or quality use of medicines. In most states and territories, pharmacists are not financially supported to deliver ODTP services, including pharmacists' time, service costs for repackaging, staff training and start-up costs for equipment (such as auto dosing pumps). Participants felt that remuneration should cover all the costs associated with providing the service. Participants also noted that there is no clear model for pharmacists to be reimbursed for dispensing LAIB.
- The ODTP process and payment system is inefficient and costly to pharmacists, and presents a significant administrative burden.
- The program is complex to deliver in community pharmacies, including the need for adequate storage for controlled drugs (particularly those in large containers), and the need for a separate treatment room within an expensive retail space.
- Lack of coordination between the Australian Government and state and territory governments in delivering the program.

Pharmacists expressed concern that they are not able to support their ODTP clients or take on more clients because of these barriers. Several participants noted that the ODTP is not financially viable for many pharmacy businesses, and some pharmacies have stopped participating in the ODTP because of these economic reasons. This affects consumer access and can have devastating effects, particularly in locations where there are few prescribers and participating dosing sites. In some regional areas, the lack of participating community pharmacies means that delivery of opioid dependence treatment falls to hospital pharmacies. Pharmacies in all states and territories rely on consumer contributions to be able to run the program, either in full or in part.

It was suggested that one-off grants could be made available to support investment in the ODTP, such as for auto dosing equipment or other set-up costs.

Participants noted the differences in PBS listings for methadone syrup 200 mL when prescribed for palliative care compared with when prescribed for opioid dependence treatment. For palliative care, the product is fully funded for a single transaction supply, including mark-up and dispensing fees. For opioid dependence treatment, the same product is funded only for the cost of the medicine, but involves multiple supplies and multiple interactions with the consumer. The only viable option is for pharmacists to charge a fee to the consumer. Participants agreed that no other PBS medicines are underfunded in this way.

Participants also noted that it is unpleasant for pharmacists to have to ask consumers to pay to receive an essential medicine.

The department confirmed that a range of funding models are being investigated as part of this review to remove barriers for pharmacists while ensuring that access is maintained for consumers.

PBS s85 vs s100 listing

Participants acknowledged that the ODTP treatment model is different to how medicines are commonly accessed and dispensed under the PBS.

Participants noted that listing ODTP medicines under s85 only would mean ODTP medicines would not be directly supplied for dispensing in correctional settings, public clinics, or other non-pharmacy setting dosing sites as these are not PBS approved suppliers for the purposes of dispensing s85 medicines. However, participants noted that many medicines are listed under both s85 and s100. For example, hepatitis C medicines were originally listed under both s85 and s100 to accommodate the requirements for servicing correctional settings and hospitals.

Participants noted that s100 medicines for renal patients are funded and provided through primary care. Chemotherapy medicines are covered under the Efficient Funding of Chemotherapy Program, which includes a preparation fee. It was suggested that the s100 rules for the ODTP could be adapted to incorporate the desirable elements of an s85 listing that would improve consumer access.

Other s100 medicines (including those that have potential for misuse, such as opioids) offer the option of a staged supply arrangement, where the pharmacy might receive a month's worth of doses but package them to supply one week of medication at a time to help people manage their medication safely. Pharmacists are reimbursed for the staged supply service, which includes packaging and dispensing. This arrangement takes into consideration the consumer's suitability for obtaining a full PBS supply of their prescribed medicine (for example, whether they are at high risk of overdose), and this is managed by the care team. Staged supply arrangements are implemented for consumers with specific circumstances or needs, and are not the default arrangement for all consumers.

The department explained that staged supply is a program under the Seventh Community Pharmacy Agreement with a specific purpose with regard to improving medication adherence. It has a small scope, with pharmacies only reimbursed for services provided to a limited number of consumers. There are also other contextual differences that would mean that the current staged supply program would require more changes than simply expanding it to include all ODTP clients. It was suggested that staged supply arrangements could be considered in the context of the next Community Pharmacy Agreement.

Maintaining access to the program

Participants noted the many types of organisations who provide services and support under the ODTP, and who have a significant interest in the outcomes of this review. This includes state and territory government services, nongovernment organisations, public and private clinics, correctional services, and many small and large operators. Any changes recommended as a result of this review must consider the entire landscape of the ODTP and ensure that all operators can access program funding, so as not to disrupt the therapeutic relationship that consumers have with their prescribers, pharmacists and the non-profit organisations that support them. The potential unintended consequences of any program changes for consumers and practitioners must be carefully considered.

Participants also noted the large differences between states and territories in the funding they contribute to the program, and considered that this should be more equitable.

Forum close

Participants were informed that the ODTP PMR draft report will be available for public consultation, and were encouraged to make further comments at that time. Participants were also encouraged to email any additional comments or specific details about structures or funding models to the department after the forum.

Appendix 1 Forum participants

External participants

Participant	Organisation
	Mental Health Commission
	Nepean Blue Mountains LHD
	Harm Reduction Australia
	Commune Digital
	The Pharmacy Guild of Australia
	Camurus
	National Drug and Alcohol Research Centre
	Turning Point
	Denison Clinic
	Society of Hospital Pharmacists of Australia
	Alfred Health / North Richmond Community Health
	Burnet Institute
	Peer Based Harm Reduction WA
	Queensland Network of Alcohol and Other Drug Agencies
	Drug and Alcohol Services SA
	South Eastern Sydney LHD
	Pharmaceutical Society of Australia
	Indivior Pty Ltd
	NSW Ministry of Health
	Medibank Private Ltd
	NSW Ministry of Health
	The Pharmacy Guild of Australia
	Queensland Health
	Prison Health Services QLD
	Alcohol and Drug Foundation
	National Drug and Alcohol Research Centre
	Indivior
	Queensland Health
	Queensland Health
	Indivior
	University of New South Wales
	Tasmanian Department of Health
	Royal Australian and New Zealand College of Psychiatrists
	Monash University
	Victorian Alcohol and Drug Association
	Drug and Alcohol Services South Australia

Participant	Organisation
	Northeast Health Wangaratta
	National Drug and Alcohol Research Centre
	Integrated Pharmacy Services Collingwood
	Pharmaceutical Rehabilitation Services
	Pharmaceutical Rehabilitation Services
	Northern Health
	Artem Health P/L
	Victorian Alcohol and Drug Association
	National Drug and Alcohol Research Centre
	Tasmanian Department of Health
	Queensland Health
	Primary Care Connect
	National Drug and Alcohol Research Centre
	Pharmaceutical Society of Australia
	The Pharmacy Guild of Australia
	Monash University
	Medsurge Healthcare
	Peninsula Health
	Canberra Health Services
	Australian Injecting and Illicit Drug Users League
	Eastern Health
	Harm Reduction Australia
	Commune Digital
	Justice Health Victoria
	University of New South Wales
	QuiHN
	NACCHO
	NT Department of Health, MHAOD Branch
	Victorian Department of Health
	NSW Ministry of Health
	Artem Health P/L
	QuiHN & QuIVAA
	NSW Ministry of Health
	NSW Ministry of Health
	WA Country Health Service
	Queensland Health
	Darling Downs Health, Alcohol and Other Drugs Service
	QuIVAA
	Harm Reduction Victoria

Participant	Organisation
██████████	Alice Springs Hospital
██████████	Top End MH AOD Services Darwin

Department of Health, review group and scribe

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Gianna Garcia	Department of Health
Joe Dwyer	Department of Health
Stefano Tomasi	Department of Health
Shakira Sloper	Department of Health
Jason Hooker	Redback Connect
Julie Irish	Biotext (scribe)